IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ALASKA

CHARLIE J. DAVIS, JR.,

Plaintiff,

vs.

ZELMER HYDEN, et al.,

Defendants.

NO: A02-0214 CV (JKS)

DEPOSITION OF HENRY LUBAN, M.D.

THURSDAY, APRIL 27, 2006, 2:02 p.m.

Anchorage, Alaska

Exhibit 11
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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ALASKA

CHARLIE J. DAVIS, JR.,
Plaintiff,
vs.
ZELMER HYDEN, et al.,
Defendants.

NO: A02-0214 CV (JKS)

DEPOSITION OF HENRY LUBAN, M.D., taken on behalf of Plaintiff, Pursuant to Notice, at MATTHEWS & ZAHARE, 431 West Seventh Avenue, Anchorage, Alaska, before Susan Campbell, Certified Shorthand Reporter for Alaska Stenotype Reporters and Notary Public for the State of Alaska.



A-P-P-E-A-R-A-N-C-E-S

For Plaintiff: MATTHEWS & ZAHARE
BY: THOMAS A. MATTHEWS
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Anchorage, AK 99501

For Defendants: STATE OF ALASKA
ATTORNEY GENERAL'S OFFICE
Department of Law
Criminal Division
BY: MARILYN J. KAMM
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Reported By: Susan Campbell
Certified Shorthand Reporter



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EXHIBITS





ANCHORAGE, AK, THURSDAY, APRIL 27, 2006, 2;02 p.m.

HENRY LUBAN, M.D.,
called as a witness on behalf of the Plaintiff, having been duly sworn upon oath by Susan Campbell, Notary Public, was examined and testified as follows:

EXAMINATION

BY MS. KAMM:

Q. Could you state your name for the record, please?

**A. Henry Luban.**

Q. Spell your last.

**A. L-u-b-a-n.**

Q. And you are a medical doctor?

**A. Correct.**

Q. Can you give us an address where the court reporter can reach you?

**A. I gave her my card.**

Q. Oh, okay.

**A. 4500 Diplomacy, Suite 207, 99508. Thanks.**

Q. Ever had a deposition taken before?

**A. Yes.**

Q. Few in your profession survive many years without it, I'm afraid.

**A. Quite a few, yes.**

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Q. I'll try to make it as painless as possible. I don't expect to be here all that long, but I do have a number of questions for you today.
**A. Sure.**
Q. So could you give me just a thumbnail sketch of your basic background, training, just so I understand?
**A. I'm a Board certified internist. And started practicing medicine in 1985. And have had a variety of positions, both clinical and administrative since then.**
Q. As I understand it, you came to Alaska first in 2004?
**A. Correct.**
Q. July or something like that?
**A. Yeah.**
Q. What brought you north?
**A. Well, we moved here from upstate New York. Alaska was a place we'd talked about living, periodically. And actually, this job came available. So I expressed an interest, and one thing led to another.**
Q. Had you had any experience with treating patients on either a temporary or occasional basis prior to 2004?

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**A. Treating patients?**
Q. Yes.
**A. I'm not sure what you mean.**
Q. Any medical practice that you'd done in Alaska --
**A. Oh, in Alaska?**
Q. Yes. (Continuing) -- prior to 2004.
**A. Not in Alaska, no.**
Q. Sorry. My question wasn't very clear. You had treated many patients prior to 2004.
**A. Oh, yeah.**
Q. Your current position then is what specifically?
**A. Medical Director, Health Services Administrator. It's kind of two positions combined into one.**
Q. And that's for the Department of Corrections?
**A. Yes.**
Q. Is there a split in your duties between the two positions?
**A. I don't look at it like that. At one time it was two separate positions. And I believe a year or two before I got here, it was combined into one. And so since I've been here, it's just been one**

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**position.**
Q. So you got two jobs for the price of one?
**A. I guess you could look at it that way.**
Q. Is it fair for me to conclude that you are the chief medical person for the Department of Corrections?
**A. Yes.**
Q. And that's the position you've held basically for the last two years?
**A. Yes.**
Q. And others who have medical issues to address all report to you?
**A. Well, yes. We do have some contract positions. They're not part of the hierarchy. But in a sense, they do report to me, yeah.**
Q. Okay. Since 2000 and -- well, strike that.
Since you began in 2004, have you made changes to the hierarchy that was then in place?
**A. Yeah. There have been some personnel changes and reporting changes, yes.**
Q. Okay. I want to focus specifically on an institution, the Palmer Correctional Center, that I'm focussed on in this case.
**A. Okay.**
Q. And have there been changes in the medical

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hierarchy in Palmer since you arrived?
**A. No.**
Q. Okay. Are you the sort of physician in charge, if you will, for the Palmer Correctional Center at this point?
**A. Well, we have a clinical director, Dr. Bingham, who clinically oversees our mid-level providers.**
Q. When you say "mid-level provider," what does that mean?
**A. PAs, physician's assistant. For clinical issues, she's really the person that has more day-to-day contact with them than I do.**
Q. Yours would be more of a supervisory role?
**A. Well, I supervise her. But I usually -- it's -- it's not that clearcut. The way we've set it up, I take care more of the administrative issues, but I get involved in the clinical issues also. There's no exact line of demarcation.**
Q. Is there currently a medical doctor on staff at Palmer Correctional Center?
**A. Well, I wouldn't use the term "on staff." We have a contract physician who goes out there three times a month. And then, of course, Dr. Bingham goes out there once a month and consults. So we provide**

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**physician oversight four -- basically four times a month.**
Q. And who's the contract doctor?
**A. Dr. Billman, Jim Billman.**
Q. Just so I can understand, what type of a doctor is Dr. Billman?
**A. He's an internist.**
Q. And Dr. Bingham?
**A. Family practitioner.**
Q. Are you familiar with the medical care that was provided at Palmer prior to 2004?
**A. I'm not sure I understand your question.**
Q. I just want to make sure I understand what you can and cannot talk about, really, as a witness. So I'm just trying to understand, have you as part of your job as the current medical director gone back to review medical care that was provided during the past --
**A. Only on a case-by-case basis, if a case like this comes up.**
Q. Where you might be asked to review --
**A. Right.**
Q. -- the specific care that was given to an inmate --
**A. Right.**

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Q. -- or patient? But other than that --
**A. No.**
Q. -- you haven't been through a systemic review?
**A. No, I haven't.**
Q. Is it still the case today that day-to-day medical care for inmates in Palmer is provided primarily by PAs?
**A. Yes. Nurses and PAs.**
Q. Can you tell me what the hierarchy is out there?
**A. Well, that's an interesting question. The PAs are the -- well, we have -- at Palmer, we have -- one of the PAs is called the institutional health care officer. And he provides clinical oversight and also direct clinical care to the staff and patient population, inmate population. So he's the supervising medical person.**
Q. And who is that person currently?
**A. Roger Hale.**
Q. Okay. And then there's another PA?
**A. He's -- they rotate clinical duties. But the other PA is the institutional health care officer at Mat-Su and, I believe, Point MacKenzie. They've kind of split up their administrative assignments.**

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Q. Who is that person?
**A. Roger Hughes.**
Q. Same two PAs that we had in 2002 then.
**A. Yes.**
Q. Do you happen to know, was Mr. Hughes the institutional health care officer for Mat-Su and Point MacKenzie back in 2002?
**A. Don't know.**
Q. And in addition to the PAs, you also have nurses on staff, correct?
**A. Yes.**
Q. And how many are out there now?
**A. I don't remember.**
Q. Do you know whether it's increased since 2002?
**A. I don't think it's changed.**
Q. Is it fair to say that Roger Hale is the senior-most medical officer on full-time staff at Palmer?
**A. You mean he's been there the longest or he's -- administratively he's in charge?**
Q. I was thinking of the latter, administratively he's in charge.
**A. Yeah, yeah.**
Q. Is there currently a period of time during

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the day, 24-hour day, at Palmer Correctional Center where there is no medical staff at Palmer?
**A. Yes.**
Q. And what are those hours, do you know?
**A. I think the nurse -- I'm just guessing, 10:00 -- 10:00 or 11:00 at night, perhaps, somewhere around there. Maybe a little earlier. I don't know exact hours. But they work until sometime in the evening and then come back the next morning.**
Q. So during the sleeping hours, if I can call it that, there may be no medical staff there.
**A. There is no medical staff.**
Q. Is that true throughout the correctional system?
**A. No.**
Q. Are there other centers where there is full-time medical staff?
**A. Yes.**
Q. And what other places have full-time medical staff?
**A. Well, the Anchorage Correctional Complex does. Our Hiland facility does. I think that's it. That's it. Just those two facilities. Oh, Fairbanks sometimes does, not always.**
Q. And how about Juneau?

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**A. No, they don't.**
Q. Can you explain for me why certain facilities have full-time coverage and others do not?
**A. Well, certainly, the ones that are -- that are busier at night, a lot of times we -- the Anchorage Correctional Complex is the -- is our big remand facility so, of course, we have a lot of people coming in at all hours. Hiland tends to have a -- I would say a sicker clientele, perhaps, than Palmer. And Fairbanks is a big remand facility as well.**
Q. You're familiar with Mr. Davis' medical care?
**A. Yes.**
Q. When did you first become familiar with that?
**A. I don't remember.**
Q. You were asked at some point in time as part of this litigation, I take it --
**A. Yes.**
Q. -- to review the care that he received?
**A. Yes.**
Q. And you did that?
**A. Yes.**
Q. Can you tell me what you did?
**A. I reviewed the chart.**

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Q. Okay. Do you have the chart there in front of you? Is that what you brought?
**A. Yes.**
Q. Mind if I take a quick look?
**A. Help yourself.**
MR. MATTHEWS: Is this the numbered set, do we know?
MS. KAMM: Doesn't look like it.
MR. MATTHEWS: I'm assuming it's the same set that I got.
MS. KAMM: I'm assuming it is, too. I brought the numbered set with me. So I'm hoping it's the same set.
MR. MATTHEWS: The little details that we lawyers get to worry about. Looks like the same set.
Q. You've never met Mr. Davis, right?
**A. No.**
Q. Never had any contact with him?
**A. No.**
Q. Never examined him in any clinical setting, right?
**A. No.**
Q. And your purpose in reviewing this chart was simply to ascertain whether his care was good, bad or otherwise?

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**A. I think I was asked to do an affidavit, if I'm not mistaken, regarding his medical care.**
Q. You did submit an affidavit. And I'm happy to show you that.
**A. I believe I did, yes. When did I write that?**
MR. MATTHEWS: I'll ask you that. It says October of 2004, which I think is -- let's mark it.
(Exhibit 1 was marked.)
MR. MATTHEWS: Take a look at Exhibit 1.
(Discussion off the record.)
BY MR. MATTHEWS:
Q. Is that a copy of an affidavit which you signed in this case?
**A. That I signed?**
Q. On the last page.
**A. Yes.**
Q. Is that your signature?
**A. Yes.**
Q. It says that it was dated October the 4th, 2004. Does that jog your memory as to when you might have prepared it?
**A. No.**
Q. Do you recall that you prepared this affidavit a year and a half or so ago?

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**A. I have -- I have no recollection of when I did it. Obviously, it's been a while since I don't remember.**
Q. Okay. Do you have any memory of this affidavit at all?
**A. Little bit, yeah. I mean, I do now that I read it, yeah.**
Q. If I can draw your attention to page three, beginning of your narrative summary, will you take a look at that for me, please?
**A. I don't have a summary -- oh, yes. Okay.**
Q. Do you see that section, paragraph five?
**A. Uh-huh, yes.**
Q. Beginning on page four about midway through that paragraph at the line marked number two, it says while at Palmer, do you see that?
**A. Yes.**
Q. Sentence reads "While he was at Palmer, there were no reports he suffered from chest pain, dizziness or other cardiovascular symptoms."
**A. Uh-huh.**
Q. And that was your opinion based upon your review of Mr. Davis' chart?
**A. Yes.**
Q. Do you know whether there were reports of

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chest pain, dizziness or other cardiovascular symptoms prior to Mr. Davis' arrival at Palmer?
**A. I think on one or two occasions when he was in Juneau, he complained of dizziness.**
Q. And you didn't see any reports of dizziness in the Palmer records.
**A. No.**
Q. Did you see any reports of high blood pressure in the Palmer records?
**A. Any reports of high blood --**
Q. Yes.
**A. He had a few readings that were mildly elevated.**
Q. And do you recall -- when you say "mildly elevated," what do you mean?
**A. That's a good question. I think he had a couple of readings, 150 systolic, perhaps, maybe as high as 160 systolic.**
Q. So we're clear for everybody reading this later, when you say "systolic," which part --
**A. Systolic blood pressure, the upper number.**
Q. Diastolic is the lower number.
**A. Correct.**
Q. So something 150 or higher would be an elevated number on the systolic?

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**A. That's not an easy question to answer. It depends on the particular patient, what their other medical problems are. I think in this fellow, 150 was mildly elevated, yes.**
Q. How about a blood pressure, a systolic number in the 190s?
**A. That's high.**
Q. That would be dangerously high?
**A. Long term, yes.**
Q. Okay.
**A. Short term, I don't know.**
Q. Do you recall seeing in the records that you were provided a blood pressure chart --
**A. Yes.**
Q. -- for Mr. Davis?
**A. Yes.**
Q. Was one kept while he was at Palmer?
**A. Yes. Would you like to see it?**
Q. Maybe you could point it out to me.
**A. I put a paperclip on it. I'll find it.**
MS. KAMM: If we could go off the record for a moment.
THE WITNESS: Here.
MS. KAMM: Or maybe you want this on the record. I think these are what I gave him yesterday,

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not what he had when he did the affidavit.
MR. MATTHEWS: Oh, okay. Okay. Hold on to that page for just a minute.
(Exhibit 2 was marked.)
BY MR. MATTHEWS:
Q. Let me ask you, if I can, Dr. Luban, is the document we've now marked as Exhibit 2 the blood pressure sheet that you were referring to?
**A. Yes.**
Q. That's the only one you've seen, correct?
**A. Yes.**
Q. It's the only one I had seen, so I just wanted to make sure we were clear.
**A. Yeah.**
Q. This shows blood pressure -- actually, Vital Sign Flow Sheet for Mr. Davis from the dates April 25, 2002 through June 11, 2002, right?
**A. Yes.**
Q. Are you aware of any vital sign flow sheet after June 11, 2002?
**A. No, I'm not.**
Q. Does that surprise you?
**A. No.**
Q. Should there be one?
**A. I don't know that they need to have a flow**

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**sheet. They could put the blood pressure in the chart with the progress notes. That's what I would do. I don't believe a flow sheet's necessary.**
Q. Having started a flow sheet like this, wouldn't it be easier to locate blood pressure readings on a continuity basis if they were all kept in one place?
**A. Might be.**
Q. Did you see regular checks of Mr. Davis' blood pressure after June 11th, 2002 in the records that you were provided?
**A. I don't recall how many there were after June, to be honest with you.**
Q. In the blood pressure readings that you have in front of you, Exhibit 2, there are some systolic readings that are at least mildly elevated, correct?
**A. Yes.**
Q. Mr. Davis was taking medication for -- taking a bunch of medication -- but blood pressure medication?
**A. Yes.**
Q. So these would be controlled readings of his blood pressure; is that true?
**A. Well, there's a couple that are a little higher than you'd like to see. But in general, I**

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**wouldn't say it's too bad. Could be a little better.**
MR. MATTHEWS: Let's mark that as the next one.
(Exhibit 3 was marked.)
BY MR. MATTHEWS:
Q. If you'd take a look at Exhibit 3, as well.
**A. Yeah.**
Q. Initially, my question to you, you mentioned that you could put the blood pressure readings in either a flow sheet, such as Exhibit 2, or in the progress reports, right?
**A. Yes.**
Q. Is what we've marked here the progress reports for Mr. Davis?
**A. Yes.**
Q. Does it appear to be a complete copy of the progress reports that you're aware of?
**A. Yes.**
Q. Is it fair for me to conclude that any readings of Mr. Davis' blood pressure while he was at Palmer should have been listed in one or the other of these two documents?
**A. Well, they may have another place they put blood pressure readings that I'm not aware of.**
Q. These are the two places you would be aware

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of?
**A. Yeah. I think sometimes in some facilities, they put them on the medication log. But I would say these are the two main places.**
Q. As the physician in charge of medical care, these are the two places you would expect to find them, true?
**A. I suppose.**
Q. If I can draw your attention to the sixth page of that exhibit --
**A. Okay.**
Q. -- specifically the entries that begin "5/8/02."
**A. Yes.**
Q. And there's a reference about midway through the page, it says "5/8/02," I think it's "addendum." And "BP, 148/90," and it's circled.
**A. Yes.**
Q. Do you see that?
**A. Yes.**
Q. And the note immediately below that appears to read "Recommend tightening BP control"?
**A. Yeah.**
Q. Is the note that follows an expression of concern about Mr. Davis' elevated blood pressure?

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**A. He's recommending it be tightened. I don't -- he says need to be concerned about decreased blood pressure and light-headedness. So he's actually -- I'm not sure exactly what he's saying there. He's recommending a range of blood pressure, I think is what he's doing.**
Q. He'd like to see the blood pressure go down into that range.
**A. That's what he's saying, yes.**
Q. Is it fair to conclude that at least as of May 8th, 2002, Mr. Davis was reporting light-headedness to the physician's assistant in Palmer?
**A. I don't believe he was -- I don't believe it's fair to say that, no.**
Q. Well, then why does it say need to be concerned about lowering BP, light-headedness?
**A. I don't know why he says that. He may have noticed in Juneau that the patient had had some light-headedness.**
Q. Is light-headedness a potential symptom of cardiac trouble?
**A. It's possible.**
Q. Is dizziness a potential symptom of cardiac trouble?

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**A. It's possible.**
Q. Elevated blood pressure a potential symptom of cardiac trouble?
**A. Elevated blood pressure is not a symptom.**
Q. What would you describe it?
**A. It's a sign.**
Q. A sign. Okay. How do you distinguish between a sign and a symptom?
**A. A symptom is something the patient reports. A sign is some objective data.**
Q. Okay. And since you can't measure objectively light-headedness, you don't consider that to be a sign?
**A. Correct.**
Q. You call it a symptom.
**A. (Witness nods head.)**
Q. So the report of light-headedness here, does that indicate to you that Mr. Davis was reporting light-headedness?
**A. What Dr. Billman wrote?**
Q. Is that Dr. Billman's writing?
**A. Yes. I don't know why he wrote that. He's not stating the patient has light-headedness. He's just saying he's concerned about decreased blood pressure, and he puts an arrow to light-headedness.**

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**But I'm not sure what he means by that.**
Q. Dr. Billman is an internist like yourself?
**A. Correct, correct.**
Q. Do you think that's a term he would use lightly?
**A. I don't think he'd put anything in the chart that he would use lightly.**
Q. So if Dr. Billman, in your experience, would have made a note about light-headedness in the chart at this point, it was significant to him, at least.
**A. Perhaps.**
Q. In your experience since coming to Alaska, is Dr. Billman a careful practitioner?
**A. Yes.**
Q. Is he given to making inaccurate notes in medical charts?
**A. Not that I'm aware of.**
Q. In your experience with Dr. Billman, if he were recommending a tightening of Mr. Davis' blood pressure control, is that a recommendation to take seriously?
**A. Yes.**
Q. Between Exhibits 2 and 3, it appears that Mr. Davis' blood pressure was checked again in Palmer up through June 11th, 2002.

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**A. Yes.**
Q. Correct? And it was monitored fairly regularly during that period of time?
You need to answer out loud. Sorry.
**A. I forgot the question.**
**(Record read.)**
THE WITNESS: Yes.
BY MR. MATTHEWS:
Q. And fluctuated somewhat?
**A. Fluctuated mildly.**
Q. It looked like the systolic number actually was a little higher, a little lower, depending upon when it was measured?
**A. Blood pressure will change quite often.**
Q. Daily, right?
**A. Correct.**
Q. Do you see any indication in the charts that you have between Exhibits 2 and 3 that Mr. Davis' blood pressure was measured again after June 11th, 2002?
**A. In Palmer or at another place?**
Q. In Palmer. I'm sorry.
**A. I don't -- I don't see anything in the chart, no.**
Q. Mr. Davis remained in Palmer until the

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latter part of October of 2002, right?
**A. He was transferred in October, yes.**
Q. Is it fair to say, then, for a period of four months, there's no indication that Mr. Davis' blood pressure was checked in Palmer, at least in the chart?
**A. In the chart that we have, no.**
Q. Do you think that's good care?
**A. I think he received essential health care.**
Q. Do you think it would be good care for a 70-year-old man with an implanted defibrillator to go four months without having his blood pressure checked?
**A. I would say the average 70-year-old man would be at home and might get his blood pressure checked every three to four months at a doctor's office, perhaps. So it's certainly within reason.**
Q. If you were treating a 70-year-old patient with an implanted defibrillator, Dr. Luban, who was not at home but was institutionalized, would you check his blood pressure more than every four months?
**A. I might. I think it all depends how he was doing, how it's been up to then.**
Q. There were expressions in the chart of concern about his blood pressure, right?
**A. There was one expression that we just went**

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**over, yes. But subsequent readings were pretty close to that target level for the next month.**
Q. Are COs in Palmer trained to measure blood pressure?
**A. I don't know.**
Q. Are they allowed to measure blood pressure?
**A. I don't know.**
Q. Is there anybody other than medical staff at Palmer who is authorized to make notes in a medical chart?
**A. Anybody other than who?**
Q. Medical staff.
**A. I don't believe so.**
Q. Which would include the PAs and the nurses or a visiting M.D., correct?
**A. Correct, yeah.**
Q. In your experience, Dr. Luban, is dizziness a common symptom for somebody with elevated blood pressure?
**A. No.**
Q. Is it a symptom which would concern you for somebody with elevated blood pressure?
**A. All symptoms need to be -- need to be looked into.**
Q. If a patient with a history of cardiac



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trouble is showing elevated blood pressure in excess of systolic 150 and reporting dizziness and feeling of light-headedness, is that of concern to you as a physician?

**A. All symptoms are of concern to me as a physician.**

Q. Can dizziness be painful?

**A. Dizziness is a symptom. It's not pain. It's a particular symptom. It has a particular description.**

Q. If a patient were reporting to you daily nose bleeds with a history of cardiac troubles such as Mr. Davis, would that be of concern to you as a physician?

**A. All signs and symptoms are of concern to me as a physician.**

Q. Is daily nose bleed a symptom or a sign?

**A. It could be either.**

Q. Which would you call it?

**A. If I saw it, it would be both.**

Q. If a patient reported to you daily nose bleed, feelings of dizziness and light-headedness, blood pressure with a systolic number in excess of 150, in your professional opinion, are those potential problems for somebody with a heart condition?

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**A. Sure. High blood pressure, heart disease, they are all potential problems. They're all problems. They're not potential problems. They're problems.**

Q. That's somebody who needs to get those symptoms under control.

**A. I didn't say that.**

Q. You don't think those symptoms need to be controlled?

**A. Which symptoms are you referring to?**

Q. Well, we listed off a bunch of them so --

**A. You listed some signs and symptoms and some illnesses.**

Q. Okay.

**A. And you asked me which symptoms need to be under control.**

Q. I'm not trying to play games with you, doctor, and I'm not --

**A. Well, it's just not that simple.**

Q. Okay. If a patient reports to you blood pressure in excess of 150 systolic number, that is a sign which you would like to see controlled?

**A. If a patient reports to me or I take their blood pressure and it's high?**

Q. Well, let's start with if the patient reports to you.

**A. If the patient took a blood pressure at home?**

Q. A patient had a blood pressure reading taken and it was out of your presence --

**A. Okay.**

Q. -- somebody else took it --

**A. Okay.**

Q. -- and reports to you that the reading showed it was in excess of 150 on the systolic number --

**A. Okay.**

Q. -- that would concern you as a physician?

**A. Everything the patient tells me concerns me as a physician.**

Q. Is that a reading with somebody such as Mr. Davis that would cause you to want to give him some different care?

**A. No. I would give the same care to everybody I see.**

Q. Would that reading when reported to you by a patient cause you to adjust a medication level?

**A. No.**

Q. Would it cause you to do anything different in the care of that patient?

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**A. Different than what? You mean, what would my plan be?**

Q. Sure.

**A. I would interview the patient. I would do a physical examination. I would make a plan. I would not make any decisions based on that one piece of information.**

Q. In the interview, what would you be hoping to learn?

**A. Oh, I would be asking all kinds of questions about -- depending on how well I knew the patient, if it was a regular patient or a new patient. I mean, there's a lot of factors involved.**

Q. A patient reporting blood pressure in excess of 150, reporting dizzy spells and light-headedness, reporting daily nose bleeds --

**A. Uh-huh.**

Q. -- would you as a physician want to be sure that that patient got a good thorough exam?

**A. If the patient came to see me in an office setting, I would do a thorough exam, depending on when the last time I saw them. If I just saw them the day before, I might not repeat the same thing.**

Q. Okay. What if it had been three months since the last exam?

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**A. I would do a -- I would -- if it had been three months from the last exam, I would do a basic physical exam focusing on the important issues.**
Q. And what would those issues be in that case?
**A. I would take the patient's blood pressure. I would examine the patient's nose. I would probably listen to the patient's heart and lungs.**
Q. Do you see any record, Dr. Luban, that Mr. Davis was seen by a medical doctor while at Palmer?
**A. No.**
Q. Is that something you looked for in your review of the records?
**A. I -- I didn't look for that in particular.**
Q. Help me understand the way the chart is done, if you can. Medical chart, to my way of understanding, is a living document where all information about a patient is typically kept. Do you agree with that?
**A. I suppose.**
Q. So all people who have reason to examine or treat or observe the patient for medical purposes would typically put a record of their --
**A. Yes.**
Q. -- findings, their exams, whatever it is

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that they were doing, correct?
**A. Yes.**
Q. And the purpose of that is to make sure that others who are treating that particular patient have full information, right?
**A. Yes.**
Q. You want to get a complete history as a doctor or a PA, whatever the person is, of what other treatment has occurred, right?
**A. Yes.**
Q. Gives you a good idea about continuity of care, right?
**A. Yes.**
Q. So what we should see in these progress notes for Mr. Davis is a statement of all of the care that he received while he was in Department of Correction's custody, true?
**A. Ideally.**
Q. And I take it from your answer that that doesn't always happen as a matter of practice.
**A. Doesn't always happen anywhere.**
Q. If it doesn't get into the chart, somebody else can't see that something was done, though, right?
**A. They might be able to infer certain things. But generally, you like to document everything that**

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**was done.**
Q. So, for example, when we're talking about blood pressure readings -- which is something that you as a physician can look at objectively, right?
**A. Right.**
Q. (Continuing) -- that's the type of thing that you would typically like to see in a medical chart, right?
**A. Right.**
Q. So that you can assure continuity of care for the patient, right?
**A. Right.**
Q. Is there any good reason you can think of, Dr. Luban, if a blood pressure reading was taken that it would not be put in the chart?
**A. No.**
Q. Are medical charts for patients periodically reviewed off-site by a physician in charge?
**A. No. On a routine basis?**
Q. Yes.
**A. No.**
Q. You mentioned early in your testimony there are what, four days a month, I think you said, where there's a physician who comes --
**A. Right.**

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Q. -- on-site?
**A. Right.**
Q. And is part of the purpose of that visit to go over charts?
**A. They go over particular inmates that the mid-levels have questions about or the supervising physicians might have questions about, having seen them before, perhaps.**
Q. And do they also see inmates while they're there?
**A. Yes.**
Q. Do you know in 2002 how often Dr. Billman was visiting Palmer?
**A. No, I don't.**
Q. You said currently it's three days a month?
**A. Correct.**
Q. Do you know how often in 2002 Dr. Bingham was visiting?
**A. No, I don't.**
Q. And currently, it's one day a month?
**A. Approximately.**
Q. You use a term in your affidavit, you refer to "one uncomplicated episode of epistaxis."
**A. Correct.**
Q. Can you explain what that is?

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**A. Nose bleed.**
Q. Can you explain what Coumadin is?
**A. Anticoagulant.**
Q. Is that a prescription that you use in your practice?
**A. Correct.**
Q. Is it a common prescription?
**A. Correct.**
Q. And what is an anti-coagulant to the layman, to those of us who are not --
**A. Inhibits blood clotting.**
Q. Is it something that is typically used with somebody who has an implanted defibrillator?
**A. Not always.**
Q. Is it common?
**A. Is it commonly used?**
Q. Yes.
**A. That's hard to say. I don't know what you mean.**
Q. Is it something that you use on a regular basis in your practice?
**A. I had a significant number of patients taking Coumadin, if that's what you mean. I don't have a practice now.**
Q. Forgive me. I appreciate the correction.

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Coumadin requires monitoring of medication levels in the blood; is that true?
**A. Requires the monitoring of a particular clotting blood test.**
Q. And what is that test?
**A. Well, right now, it's called the INR test, internal normalized ratio.**
Q. I've also heard a term called a PT INR test.
**A. Well, the PT is not really used anymore. It's the INR. That's the most accurate test.**
Q. You say that's internal normalizing --
**A. I believe that's what it stands for, internal normalized ratio.**
Q. In layman's terms, what does that mean?
**A. I don't know.**
Q. Is it a test for determining the therapeutic level of a particular drug in the bloodstream?
**A. No. It's a test that monitors the effectiveness of a particular medication, degree of effectiveness.**
Q. How is it typically reported?
**A. It's a number.**
Q. Is there a scale or a range that is considered to be effective?
**A. There's a therapeutic range, depending on what you're treating.**
Q. Is the goal typically to keep the level, the number, if you will, within that therapeutic range?
**A. Yes.**
Q. And regular testing allows you to do that?
**A. Yes.**
Q. You can adjust the level of the medication, if you will, prescription level?
**A. Usually you can, yes.**
Q. Was an INR test done regularly on Mr. Davis?
**A. Yes.**
Q. Once a month while he was at PCC?
**A. I think sometimes he had them more than one a month. I don't remember exactly. But my opinion, it was regular.**
Q. It was adequate, in any event --
**A. Yes.**
Q. -- as far as you're concerned.
**A. Right.**
Q. Were there instances where the measured level of Coumadin in Mr. Davis' blood by the INR test were out of the therapeutic range?
**A. Minimally. I didn't notice anything that was significant.**

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Q. Did you notice instances where it was outside the range?
**A. Minimally.**
Q. What do you mean by minimally?
**A. Well, I think there was one reading, it was 1.9 instead of two. And there might have been another one that was 3.5 instead of three. Not what I call clinically significant.**
Q. Ten percent or so out of the range, but not clinically significant; is that your term?
**A. Correct.**
MS. KAMM: I think 1.9 instead of two is not -- it's five percent.
THE WITNESS: About five percent.
BY MR. MATTHEWS:
Q. Right you are. 3.5 instead of two --
**A. A little over ten percent.**
Q. -- is a little over ten percent, right?
MS. KAMM: I'm sorry. What was your last question?
(Record read.)
THE WITNESS: Instead of three.
MR. MATTHEWS: I'm sorry. Instead of three. I misspoke.
MS. KAMM: I wasn't sure.





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BY MR. MATTHEWS:
Q. The range is two to three, right?
**A. In this particular patient, the goal was two to three, correct.**
Q. I've messed up that whole area. Let me just see if I can straighten this out.
**A. Yeah.**
Q. The therapeutic goal for this particular patient was a range of 2.0 to 3.0, correct?
**A. Correct.**
Q. And there were instances where the measured level of Coumadin was below 2.0, 1.9 in at least one instance, right?
**A. Yes.**
Q. And there were also at least one instance where it was high --
**A. 3.5.**
Q. -- 3.5, correct?
**A. Right.**
Q. Those two numbers, 1.9 and 3.5, respectively, in your medical opinion, were still within close enough range.
**A. As long as you're monitoring regularly, I think they're okay, yes.**
Q. Were you aware, Dr. Luban, that when

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Mr. Davis was first taken into State custody his private physician had recommended monitoring tests be done every two weeks?
**A. Was I aware or am I aware now?**
Q. Well, you weren't here at the time. So are you aware now?
**A. I'm not aware, no.**
Q. Do you know whether or not medical records were collected from Mr. Davis' private physicians --
**A. I think they were.**
Q. -- private physicians and hospitals?
**A. Yes, I believe they were.**
Q. Including records relating to his implanted defibrillator?
**A. Yes.**
Q. From Virginia Mason?
**A. Yes, I believe so.**
Q. And also from his private physician in Haines?
**A. I believe so.**
Q. Is it fair to say, Dr. Luban, that Mr. Davis was not your typical patient -- excuse me -- typical inmate?
**A. That's not fair to say. You don't have a typical inmate.**

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Q. Is it fair to say that he came to State custody with more than a typical level of medical problems?
**A. More than -- yes, that's fair to say.**
Q. Not common to have somebody arrive in State custody with an implanted defibrillator, is it?
**A. Not common, no.**
Q. In the almost two years that you have been the medical director, can you think of any other prisoners who have arrived in State custody with an implanted defibrillator?
**A. I honestly don't keep track of that. So I don't know. I can't answer that question.**
Q. As you sit here today, can you think of anybody else?
**A. No, I can't.**
Q. As a medical practitioner, would you agree with me that the medical needs of a 70-year-old man with an implanted defibrillator are different than that of the average population?
**A. Yes.**
Q. Greater medical needs?
**A. Usually.**
Q. Requires greater medical monitoring?
**A. Usually.**

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Q. Mr. Davis had quite a number of prescriptions that he was taking while he was in State custody, correct?
**A. Yes.**
Q. The Coumadin was dispensed to him, correct?
**A. Coumadin was what?**
Q. Dispensed to him. It wasn't something --
**A. I believe it was called keep-on-person, yes.**
Q. That was going to be my question. There were a number of mediciations that he had on a keep-on-person basis.
**A. I'm not positive about that, but I believe it was.**
**No. I could be wrong. I honestly -- to be honest with you, I don't know how the Coumadin was handled. It may not have been KOP.**
Q. As an acronym, I've seem SM-ML.
**A. That would be the med line, the Self-Medication - Med Line. I believe that's what that stands for.**
Q. So if Coumadin were given to him on an SM-ML basis, according to the medical records, then he would have to come to the med line?
**A. Yes.**
Q. What's your understanding of how the med





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line works at Palmer?
**A. I don't have any understanding of how it works.**
Q. Is -- strike that.
Does the med line come under your supervisory control in any way?
**A. Everything in inmate health comes under my supervision.**
Q. Is the med line part of inmate health?
**A. Yes.**
Q. You don't know how -- physically how it works --
**A. No.**
Q. -- in Palmer?
**A. No.**
Q. If an inmate is told med line is over for the day, you lose, you don't get your meds today, would that be acceptable medical treatment, as far as you're concerned?
**A. I'd have to know more about the circumstances. I can't answer that.**
Q. As a physician, would that be the type of medical treatment you would condone?
**A. I'm not going to answer that question. I don't know the circumstances. That's a blanket**

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**statement that's obviously got -- has a lot more to it than that. I'm not going to answer that.**
Q. Do you understand the question?
**A. I do, but --**
Q. You just don't want to answer?
**A. I don't think you've given enough information for me to answer that question.**
Q. Let me give you the hypothetical this way: Med line in the evening has a number of inmates lined up. Time comes for lockdown. And the CO who's dispensing meds at that time says med line is over now. Those of you that don't have your meds don't get your meds today, and cuts the line behind a specific inmate. Everybody else goes back to their cells. Would that be acceptable medical treatment?
**A. From what you're describing, it does not sound acceptable.**
Q. Have you ever heard such a complaint?
**A. No.**
Q. Are there any instances that you can think of, Dr. Luban, where that would be an acceptable practice?
**A. There might be a security issue. Like I say, this is very complicated.**
Q. Sure. I understand security. I mean, if

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you've got a crisis --
**A. I mean, these are prisoners we're talking about. And they have difficult situations. So who knows what could be happening at that time.**
Q. Absent a security issue with the prisoners, can you see any medical justification for that?
**A. Doesn't sound like it.**
Q. In the med line medications are given out by COs; is that right?
**A. At some of our facilities when there's no nurse around, I believe that's the case.**
Q. Including Palmer?
**A. I don't know how they do it there.**
Q. Do you know whether the COs that are actually giving out medications in the med line are given any special training?
**A. Yes. I believe there is -- there is med line training.**
Q. Do you know what's entailed in that?
**A. Well, we have a nurse from our Central Office that goes out to the facilities and gives training, but I'm not sure exactly what it involves.**
Q. Do you know who that nurse is?
**A. Joyce DeGroot.**
Q. Last name?

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**A. Joyce DeGroot, D-e, capital G-r-o-o-t.**
Q. Do you know if she was the person who was doing med line training in 2002?
**A. I don't know.**
Q. Do you know if there had been any changes to the way med lines were run since 2002?
**A. I have no idea.**
Q. Have you instituted any changes to the way med lines are run since you came onboard?
**A. No.**
Q. Have you instituted any changes to the way prescriptions are given out at all since you came onboard?
**A. The way prescriptions are given out or medications are administered? I'm not sure what your question is.**
Q. The way medications are administered.
**A. Have I instituted any changes? Not that I'm aware of.**
Q. Would you agree with me, Dr. Luban, that Mr. Davis was a prisoner who had significant medical needs?
**A. Yes.**
Q. Serious medical needs?
**A. He had serious medical problems.**

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Q. He had serious medical problems when he came into State custody, right?
**A. He had a history of serious medical illness, yes.**
Q. And if not properly monitored, he was at significant risk, wasn't he?
**A. Correct.**
Q. In fact, life-threatening?
**A. Could be.**
Q. He had a serious heart condition, right?
**A. Correct.**
Q. And if not properly monitored, he could die, right?
**A. That would be a stretch, but yes.**
Q. He had suffered cardiac arrests before?
**A. Yes.**
Q. And was at significant risk for further cardiac problems?
**A. I would say so.**
Q. That's why he had an implanted defibrillator, right?
**A. I believe so.**
Q. And you don't get those unless you've got a serious heart condition, right?
**A. I believe so.**

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MR. MATTHEWS: Okay. Thank you, doctor. I appreciate it.
MS. KAMM: Thank you.
(Whereupon, the deposition was concluded at 3:09 p.m.)
(Signature pending.)

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CERTIFICATE

I, SUSAN CAMPBELL, Certified Shorthand Reporter and Notary Public in and for the State of Alaska, do hereby certify that the witness in the foregoing proceedings was duly sworn; that the proceedings were then taken before me at the time and place herein set forth; that the testimony and proceedings were reported stenographically by me and later transcribed by computer transcription; that the foregoing is a true record of the testimony and proceedings taken at that time; and that I am not a party to nor have I any interest in the outcome of the action herein contained.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal this _____ day of _____ 2006.

_____
SUSAN CAMPBELL, CSR
My Commission Expires 4/26/08

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WITNESS CERTIFICATE
RE: Davis vs. Hyden, et al.
CASE NO.: A02-0214 CV (JKS)
DEPOSITION: Henry Luban, M.D.
DATE TAKEN: April 27, 2006

I hereby certify that I have read the foregoing deposition and accept it as true and correct, with the following exceptions:

| Page | Line | Description/Reason for Change |
|---|---|---|
| | | |

_____ _____
SIGNATURE DATE

Please sign your name and date it on the above line.
(As needed, use additional paper to note corrections, dating and signing each page.) (SC)

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